IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
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November 26, 2008

Thair Pond
Tomorrow's Hope - Navarro
1655 Fairview Avenue Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Navarro, Provider #13G061

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Navarro, which was conducted on November 21, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **December 9, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by December 9, 2008. If a request for informal dispute resolution is received after December 9, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

TOMORROW'S HOPE
1655 FAIRVIEW AVENUE. SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

Michael Case
Health Care Surveyor
Non-Long Care
Bureau of Facility Standards
PO Box 83720
Boise, Idaho 83720-0036

3 December 2008

RE: Statement of Corrections for Navarro Survey

Dear Mr. Case,

Please find attached our Statement of Corrections for deficiencies found during your recent survey of our Navarro Facility. I believe we have made corrections as necessary to come into compliance with the rules and regulations.

Thank you for conducting your survey in a manner to minimize the disruption for staff and residents. As you well know, we do consider the survey process as an important part of our quality assurance program.

If you have any questions, please contact me at the above address and numbers.

Sincerely,

Thair Pond
Administrator

Incl.
Cc: file, facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G061	A. BUILDING _____ B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - NAVARRO	946 NORTHWEST 12TH MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey. The surveyors conducting the survey were: Michael Case, LSW, QMRP, Team Leader Matt Hauser, QMRP Common abbreviations used in this report are: CLIA - Clinical Laboratories Improvement Act IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record QMRP - Qualified Mental Retardation Professional	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures and staff interview, it was determined the facility failed to adequately develop policies necessary to protect individuals from abuse, neglect and/or mistreatment by the Administrator for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for individuals to be unprotected from abuse, neglect and/or mistreatment. The findings include: The facility's Treatment of Clients/Residents policy, revised September 2007, did not include procedures to be followed if the Administrator was the staff person accused of abuse. Therefore, the policy did not identify who was responsible to	W 149	W149 Policies corrected to include procedures necessary to protect individuals from abuse, neglect, and/or mistreatment by the Administrator prior to Surveyors leaviang. Administrator and Board of Directors responsible by 11/20/08 Policy and Procedures correct to reflect policies to protect individuals if the ccused is the Administrator. Board of Directors to review Polices at least annually to ensure they meet rules and requirements. Administrator and Board of Directors responsible by 12/31/08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12/03/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 perform tasks assigned to the Administrator including, but not limited to, interviewing staff and residents, contacting required agencies, notifying parents/guardians, forming a review committee, and taking corrective action. When asked, the Administrator stated on 11/19/08 at 2:30 p.m., the Treatment of Clients/Residents policy did not cover procedures to be followed if the Administrator was the staff person accused of abuse. The facility failed to ensure the Treatment of Clients/Residents policy included instructions to follow if the Administrator was the staff accused of abuse, neglect, and/or mistreatment.	W 149		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure active treatment schedules were sufficient to provide a range of options and direction to staff for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in schedules which were not individualized or sufficient to direct staff in providing consistent active treatment to individuals. The findings include: 1. An observation was conducted at the facility on 11/17/08 from 3:10 - 4:35 p.m. During that time, two large pieces of poster board were noted to be	W 250	W250 All clients' active treatment schedules updated to meet requirements. QMRP responsible by 12/31/08 Client active treatment schedules will be created to reflect individual needs and give sufficient direction to staff to provide consistent active treatment. Active treatment schedules will be reviewed at monthly QA and at least quarterly to ensure they are current with current treatment plan and individual needs. QMRP and Program Director responsible by 12/31/08	

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W 250	Continued From page 2 hanging on the wall in the living room. Half-hour time frames from 2:00 p.m. - 8:00 p.m. were listed on the poster board. Each time block included a short list of tasks. Examples included, but were not limited to, the following: "2:00 - 2:30 - [Individuals #3 and #7's initials] home - set up zones, count [Individual #6's initials] carbs (carbohydrates) for dinner..." "2:30 - 3:00 - [Individuals #1, #3, and #4's initials] arrive - toileting - check backpacks [and] com. (communication) logs - snack - [Individual #6's initials] staff pick up [Individual #2's initials]..." "3:00 - 3:30 - structured leisure (outside play, puzzles, books, coloring, etc.)..." "3:30 - 4:00 - Sensory Programs" A sheet of paper, hanging on a different wall, included a list of tasks that could be completed as individuals' sensory programming. However, the schedule posted on the poster board did not include references to direct staff to this additional list. "4:00 - 4:30 - [Individual #6's initials] arrives - 1:1 time - meds - toileting..."	W 250		

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W 250	Continued From page 3 No additional information was included regarding individuals' programs or objectives, individuals' preferences, or information to direct staff if an individual finished a program before the allotted time frame was completed. Two of the five staff working during the observation were asked about the individuals' active treatment schedules. Both staff stated the only schedule was the one hanging on the wall. Additionally, individuals' floor books were reviewed during the observation. No additional information or schedules were noted for the 2:00 - 8:00 p.m. time frame. When asked during an interview on 11/20/08 from 2:00 - 3:30 p.m., the QMRP stated the active treatment schedules were not individualized and did not contain sufficient information to direct staff. The facility failed to ensure active treatment schedules for Individuals #1 - #7 were individualized and contained sufficient information to direct staff.	W 250		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by:	W 289		

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W 289	Continued From page 4 Based on observation, record review, and staff interview it was determined the facility failed to ensure techniques used to manage inappropriate behavior were incorporated into the program plans of 1 of 2 individuals (Individual #4) whose restrictive behavior interventions was reviewed. This resulted in interventions being used that were not included in the individual's program plan. The findings include: 1. Individual #4's 8/22/08 IPP stated she was a 14 year old female diagnosed with profound mental retardation, autism, and mood disorder. a. On 11/18/08 at 3:15 p.m., Individual #4 was observed walking with a staff outside in front of the house. Individual #4 threw herself to the ground. Individual #4's helmet was not observed to be present with the staff. When asked where Individual #4's helmet was, the QMRP, who was present during the observation, stated staff should have the helmet with them when walking Individual #4 outside. Individual #4's Behavior Intervention Plan, updated 9/8/08, stated in the "Instructions for Intervention" section, when Individual #4 began hitting her head on a hard surface without her hands in between her head and the hard surface, or was biting herself, staff were to put a helmet on her and ignore the behavior (walk away, but monitor and ensure she was safe). Once she had quit biting herself and/or hitting her head, staff were to remove the helmet and direct her to an activity and reinforce her with social praise. However, the plan did not include instructions to staff regarding where the helmet was to be kept, or how staff would be able to walk away from	W 289	W289 Client's behavior plan to be revised to include instrutions for 1:1 staffing and how to use the helmet. QMRP responsible by 12/31/08 The use of systematic interventions to manage inappropriate client behaviors will be incorporated into the clients individual program plan. PSR for behavior plans to be revised to include methodology and to be completed annually and reviewed at monthly QA at least quarterly. QMRP and Prpgram Director responsible by 12/31/08	

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W 289	Continued From page 5 Individual #4 in in all settings (i.e., out in the yard, in the community, etc.). During an interview on 11/20/08 from 2:00 - 3:30 p.m., the QMRP stated Individual #4's Behavior Intervention Plan did not include specific instructions regarding the use of the helmet, or where the helmet should be kept in relation to Individual #4. b. Individual #4's Behavior Intervention Plan stated she had a one on one staff. The plan contained no additional information regarding the one on one staff, such as where the staff were to be in relation to Individual #4 (i.e., within arms length or within line of sight) and how far staff could be from Individual #4 in different locations (i.e., in the same room, in the back yard as long as visible through the window, in her bedroom, etc.), or if staff were required to be with Individual #4 at all times. When asked if the plan defined Individual #4's one on one staff, during and interview from 2:00 - 3:30 p.m. on 11/20/08, the QMRP stated the Behavior Intervention Plan did not and more specific instruction should have been included. The facility failed to ensure Individual #4's Behavior Intervention Plan provided clear and sufficient directions to staff on how to implement the intervention strategies.	W 289		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.	W 325		

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W 325	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a routine screening laboratory examinations were provided to 1 of 4 individuals (Individual #2) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include: 1. Individual #2's 5/28/08 IPP stated she was a 46 year old female whose diagnoses included profound mental retardation and seizure disorder Individual #2's medical record was reviewed and showed routine blood work had been completed on 7/2/08. However, a cholesterol screening was not included. Individual #2's record did not contain any information regarding cholesterol screening. When asked during an interview on 11/20/08 from 2:00 - 3:30 p.m., the LPN stated cholesterol screening had been overlooked and not completed for Individual #2. The facility failed to ensure Individual #2 received standard laboratory screenings.	W 325	W325 Client cited to have cholseterol tested. Nurse responsible by 12/31/08 It shall be standard procedures for adults 18 and older to have required routine screening laboratory at least every 2 years or as recommended by the pysician. Screenings to be reviewed at monthly QA and at least quarterly. Nurse responsible by 12/31/08	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to	W 369		

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W 369	Continued From page 7 ensure medications were administered without error for 1 of 6 individuals (Individual #1) observed to take medications. This resulted in an individual not receiving the full dose of medications. The findings include: 1. Individual #1's 4/25/08 stated he was a 17 year old male whose diagnoses included profound mental retardation and Down's Syndrome. His MAR stated he was to receive the following medications at 6:30 a.m.: - Lamictal (an anticonvulsant drug) 100 mg - Vitamin E (a supplement) 200IU - Vitamin C (a supplement) 250 mg - Chew Vitamin with iron - Levothyroxine (a hormonal drug) 0.075 mg - Trileptal (an anticonvulsant drug) 600 mg - Senna-Gen (a laxative drug) 1/2 tablet - Minocycline (an anti-infective drug) 100 mg - Power pudding (a laxative mixture) 1/2 cup During an observation on 11/18/08 from 6:05 - 7:20 a.m., a staff was noted to crush Individual #1's medications and pour them into a bowl. When asked, the staff stated the bowl contained a mixture of yogurt and Power pudding. The staff was noted to mix the crushed medications into the yogurt mixture. Individual #1 ate several bites from the bowl and then pushed the spoon away. There was no less than 4 tablespoons of the mixture left in the bowl and pill fragments were visible in the mixture. The staff took the bowl to the kitchen sink and rinsed the mixture down the drain. When asked during the observation, the staff stated Individual #1 does not always eat all of the mixture. When asked how she ensured Individual	W 369	W369 Staffed trained how to assist with medications to ensure all medications are taken as prescribed. Nurse responsible by 12/31/08 All medication programs to include specific instruction how to assist with medications and how to ensure allmedications is taken as per physcian instructions. Observations of medication delivery will be observed at least monthly by either QMRP, PQ, or nurse. Observations will be reviewed at monthly QA. QMRP and Program Director responsible by 12/31/08	

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W 369	Continued From page 8 #1 received all of his medications, the staff stated she tried to pour the medications in one spot of the mixture. When asked during an interview on 11/20/08 from 2:00 - 3:30 p.m., the LPN stated Individual #1 should have consumed all of the yogurt and Power pudding mixture. The LPN stated it would not be possible to ensure all mediations were taken unless all of the mixture was consumed. The facility failed to ensure Individual #1's medications were administer without error.	W 369		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure drugs were stored securely for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in controlled drugs not being kept under a double lock system. Findings include: 1. During an observation on 11/18/08 from 6:05 - 7:20 a.m., Individual #7 was observed to receive Xanax (an anxiolytic drug). The medication was observed to be stored in the main medication storage cabinet under a single lock. During an environmental assessment on 11/19/08 from 11:05 - 11:45 a.m., the following drugs were noted to be stored under single lock in the medication cabinet:	W 381	W381 Double locks have been placed on medicine cabinet to ensure requirements have been met. QMRP and Maintenance responsible by 12/31/08 Medication cabinet will have double locks to meet requirements. Monthly maintenance check list to include medication cabinet. Maintenance checks to be reviewed at monthly QA. Para Q responsible by 12/31/08	

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W 381	Continued From page 9 - Individual #1's Diazepam (an anxiolytic drug) 5 mg, one blister pac. - Individual #3's Diazepam (an anxiolytic drug) 5 mg, one blister pac with one and one half pills per blister and one blister pack with one pill per blister. - Individual #7's Xanax (an anxiolytic drug) 0.5 mg, three blister pacs, and Lorazepam (an anxiolytic drug) 0.5 mg, one blister pac. The Nursing 2008 Drug Handbook stated Xanax, Diazepam, and Lorazepam were Schedule IV controlled substances. When asked, the LPN who was present stated she was not aware controlled drugs were required to be double locked. The facility failed to ensure controlled drugs were kept under a double lock system.	W 381		
W 394	483.460(n)(2) LABORATORY SERVICES If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure a CLIA certification or waiver had been obtained prior to implementing blood glucose screening test for 1 of 1 individuals (Individual #6) who required glucose screenings. The findings include:	W 394	W394 The facility has contacted proper authorities twice to receive application for CLIA Certification on 11/21/08 and again on 12/03/08. The application will be completed upon reception. Nurse and Administrator responsible by 12/31/08 Application for CLIA to be completed as soon as it is recieved. The facility will review need for CLIA certification requirment at least annually, during new resident admitance, and at client health need change. Program Drector responsible by 12/31/08	

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W 394	Continued From page 10 1. Individual #6 was an 11 year old male whose diagnoses included moderate mental retardation and type 1 diabetes. During an observation on 11/18/08 from 6:05 - 7:20 a.m., Individual #6 was observed to complete a blood glucose test as part of his medication administration routine. When asked during an interview on 11/20/08 from 2:00 - 3:30 p.m., the LPN stated the facility had not obtained a CLIA certificate or waiver to perform blood glucose tests. The LPN stated she was not aware a certificate or waiver was required. The facility failed to ensure a CLIA certificate or waiver was obtained prior to implementing blood glucose screenings for Individual #6.	W 394		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses nor identify problem areas. The findings include: 1. During a review of the facility's evacuation drills on 11/19/08, the following was noted: - There were no evacuation drills completed on the graveyard shift for over 12 months. - There was no evacuation drill completed during	W 440	W440 QMRP trained to ensure there is a review of evacuation drills to enusre compliance of requirements of a minimum of 1 drill per quarter per shift. Program Director responsible by 12/31/08 Evacuation drills will be held at least once per shift per quarter to meet requirements. All drills will be documented and documentation will be physically checked during monthly QA to ensure all requirements have been met. QMRP responsible by 12/31/08	

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	13G061	A. BUILDING _____ B. WING _____	11/21/2008

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W 440	Continued From page 11 the first quarter (i.e, January, February, March) 2008 for the p.m. shift. When asked during an interview on 11/20/08 from 2:00 - 3:30 p.m., the QMRP and Program Director both stated the drills had not been completed. The Program Director stated the former Para-QMRP had provided false verbal reports that the drills had been completed, but the drills had not actually been completed. The facility failed to ensure ensure evacuation drills were conducted at least quarterly on all shifts.	W 440		
W 481	483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure a record of food served was kept for 30 days. This failure directly impacted 3 of 7 individuals (Individuals #4, #5, and #7) observed to not eat the food served, and had the potential to impact the other 4 individuals (Individuals #1, #2, #3, and #6) residing in the facility. This resulted in the potential for individuals to not receive an adequate variety of food. Findings include: 1. During an observation on 11/18/08 from 4:55 - 6:00 p.m., the facility's menu was reviewed and documented the following meal was to be served: - Taco dinner, 1 cup - Green salad, 1 cup - Dressing, 2 tablespoons	W 481	W481 Staff have been trained to document what clients have eaten each meal. QMRP responsible by 12/31/08 To ensure there is proper documentation of client food intake, a food intake sheet has been added to each client's book to be filled out at each meal by staff. Food intake sheet to be reviewed by QMRP monthly. QMRP responsible by 12/31/08	

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W 481	Continued From page 12 - Brown rice, 1 cup - Oatmeal cookies, 2 - Milk, 8 oz. However, individuals were observed to have meals other than the meal scheduled as follows: a. Individual #4 was observed to refuse all food offered to her. b. Individual #5 was observed to refuse the meal listed on the menu. Individual #5 was noted to eat chocolate pudding and tomatoes. c. Individual #7 was observed to refuse the meal listed on the menu. Individual #7 was observed to eat a peanut butter sandwich, a banana, and pretzels. When asked if a record of foods actually served was kept (i.e. reflecting substitutions, refusals, etc.), a staff present during the observation stated they did not record what foods were actually served to individuals. When asked during an interview on 11/20/08 from 2:00 - 3:30 p.m., the QMRP and LPN both stated the menu would be marked if an entire meal was changed for the facility, but individual meal substitutions were not kept. The facility failed to ensure a record of food actually served was kept for Individuals #4, #5, and #7.	W 481		

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149.	MM177	MM177 refer to W149	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197	MM197 Refer to W289.	
MM238	16.03.11.080.03(h) Access to Resident's Records To be given access to all of the resident's records that pertain to his active treatment, subject to the requirements specified in Idaho Department of Health and Welfare Rules, Section 05.01.300 through Subsection 05.01.301,06, and Sections 05.01.310 through 05.01.339, "Rules Governing Protection and Disclosure of Department Records." This Rule is not met as evidenced by: Refer to W250.	MM238	MM238 Refer to W250	
MM337	16.03.11.110.04(c) Fire Drills	MM337		

Bureau of Facility Standards

Thor S. [signature] [signature] TITLE 12/3/08 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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MM337	Continued From page 1 A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W440.	MM337	MM337 Refer to W440	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. The findings include: During an environmental survey conducted on 11/19/08 from 11:00 - 11:45 a.m., the following concerns were noted: Living Room: - The brown couch contained food debris (pretzels, crumbs, and candy) between and beneath the cushions. - There were 3 one inch chip holes and 7 smaller chipped areas in the plaster on the wall behind the large couch.	MM380	MM380 Cited deficiencies will be either cleaned, repaired, or replaced as needed to meet requirments. QMRP responsible by 12/312/08	

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MM380	Continued From page 2 - There were 3 one inch areas that were thread bare on the cloth of the green recliner. Main Bathroom: - The toilet bolt covers were missing and the bolts were rusted. Individual #3 and #4's bathroom: - The toilet bolt covers were missing and the bolts were rusted. Kitchen: - There were 4 one-half inch chip holes behind the metal garbage can in the kitchen wall area near the pantry.	MM380		
MM419	16.03.11.120.06(b) Medical Supplies and Equipment The facility must provide safe and adequate storage of medical supplies and equip a space appropriate for the preparation of medications. This Rule is not met as evidenced by: Refer to W381.	MM419	MM419 Refer to W381	
MM672	16.03.11.07(a) Menu Preparation Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by:	MM672	MM672 Refer to W481	

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MM672	Continued From page 3 Refer to W481.	MM672		
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W325.	MM750	MM750 Refer to W325	
MM759	16.03.11.27.02(f)(v) Medication Error Any medication error must be reported immediately to the resident's attending physician and documented in the resident's record. This Rule is not met as evidenced by: Refer to W368.	MM759	MM759 Refer to W368	